PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council held Tuesday, July 26, 2005, 10:00 a.m., at the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Paul J. Cote, Jr., Commissioner, Department of Public Health, Ms. Phyllis Cudmore, Mr. Manthala George, Jr., Ms. Maureen Pompeo, Mr. Albert Sherman (arrived at 10:13 a.m.), Mr. Gaylord Thayer, Jr., and Dr. Martin Williams. Council Members Ms. Janet Slemenda and Dr. Thomas Sterne were absent. Also absent was Department of Public Health General Counsel, Atty. Donna Levin, therefore Atty. Susan Stein, Deputy General Counsel acted on her behalf.

Commissioner Cote, Chair, announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Mr. Michael Botticelli, Assistant Commissioner, Bureau of Substance Abuse and Control; Ms. Sally Fogerty, Associate Commissioner, Center for Community Health; Ms. Gillian Haney, Director of Surveillance, Bureau of Communicable Disease and Control; Ms. Holly Hackman, Epidemiologist, Injury Surveillance Program; Attys. Howard Saxner and Carol Balulescu, Deputy General Counsels, Office of the General Counsel; Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control; Ms. Joan Gorga, Acting Director and Mr. Jere Page, Senior Analyst, Determination of Need Program.

RECORDS:

After consideration, upon motion made and duly seconded, it was voted (unanimously) [Mr. Sherman not present to vote] to approve the Records of the Public Health Council Meetings of May 24, 2005.

PERSONNEL ACTIONS:

In a letter dated July 11, 2005, Paul Romary, Executive Director, Lemuel Shattuck Hospital, Jamaica Plain, recommended approval of appointments and reappointments to the various medical and allied health staffs of Lemuel Shattuck Hospital. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously) [Mr. Sherman not present to vote] That, in accordance with recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, chapter 17, section 6, the following appointments and reappointments to the various medical and allied health staffs of Lemuel Shattuck Hospital be approved:

APPOINTMENTS:	MASS. LICENSE NO.:	STATUS/SPECIALTY:
Duncan Macourt, MD	223578	Consultant/Psychiatry
Matthew McGonagle, MD	223459	Consultant/Psychiatry
Jonathan Levine, MD	223289	Internal Medicine

Steven Benyas, MD	211446	Psychiatry
Julio Rodriguez, MD	223755	Opthalmology
REAPPOINTMENTS:	**MASS. LICENSE NO.:**	**STATUS/SPECIALTY:**
Joseph Cohen, MD	27226	Active/Medical Oncology
Carol Gamer, MD	54221	Internal Medicine/Critical Care
Ewa Preneta, MD	80259	Gastroenterology
Yogeshewar Dayal, MD	34017	Consultant/Pathology
Arthur Rabson, MD	71947	Consultant/Pathology
Angelo Ucci, MD	40805	Consultant/Pathology
Sarah Bachrach, PA	206	Allied Health Professional/Medicine
M.Rebecca Heaton, PA	334	Allied Health Professional/Medicine
Robert McMackin, PhD	3317	Allied Health Professional Psychology

In a letter dated July 11, 2005, Blake Molleur, Executive Director, Western Massachusetts Hospital, recommended approval of reappointments to consulting medical staff of Western Massachusetts Hospital. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously) [Mr. Sherman not present to vote] That, in accordance with the recommendation of the Executive Director of Western Massachusetts Hospital, under the authority of the Massachusetts General Laws, chapter 17, section 6, the following reappointments to the consulting medical staff of Western Massachusetts Hospital be approved:

REAPPOINTMENTS:	**MASS. LICENSE NO.:**	**STATUS/SPECIALTY:**
Tedd Ackerman, MD	78810	Psychiatry
Kenneth Jaffe, MD	47691	Psychiatry

In a letter dated July 7, 2005, Dr. Ellen Nelson, Associate Commissioner for Clinical and Laboratory Services, Department of Public Health, and Arthur M. Pappas, Chairman, Board of Trustees, Massachusetts Hospital School, recommended approval of the **appointment of Thomas J. Martin to the Board of Trustees of Massachusetts Hospital School.** Mr. Martin is the founder and President of Cramer Productions, a unique, full-service, integrated marketing communications company offering services in event and video production, as well as interactive media, web casting, print and direct marketing. The company employs 130 people and works out its Norwood facility. He has made enormous contributions to many charities in the greater Boston area with little fanfare, including producing numerous videos, documentaries and marketing material for the Massachusetts Hospital School. He has served on the Massachusetts Hospital School Development Committee since its inception and was the recipient of the Dr. Arthur M. Pappas Award at the 2001 Gala. The award is given in recognition of dedicated work on behalf of physically challenged children. He is also currently Chairman of the Board at Caritas Christi Hospital. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously) That, in accordance with recommendation of the Associate Commissioner for Clinical and Laboratory Services, Department of Public Health, and Dr. Arthur M. Pappas, Chairman, Board of Trustees, Massachusetts Hospital School, under the authority of

the Massachusetts General Laws, chapter 111, §3A, the appointment of Thomas J. Martin to the Board of Trustees at the Massachusetts Hospital School be approved.

Speaker on Item #5 (BRN Corporation):

Mr. Brad McDougall, speaking on behalf of Congressman Marty Meehan, addressed the Council in support of Determination of Need Application #3-3A95. See item #5 for further information. Note: Council Member Sherman arrived during Mr. McDougall's testimony.

STAFF PRESENTATION: "The Commonwealth of Massachusetts' Substance Abuse Services Strategic Plan" presented by Michael Botticelli, Assistant Commissioner, Bureau of Substance Abuse Control, and Sally Fogerty, Associate Commissioner, Center for Community Health:

In August 2004, the Lieutenant Governor held a series of roundtable discussions with federal, state and local government officials on substance abuse. As a result, MDPH embarked on an interagency, inter-secretariet and inter-branch effort designed to:

- Integrate the needs, concerns and ideas of key stakeholders across government agencies,
- Incorporate the involvement and feedback of providers, communities, advocacy groups and others,
- Generate a strategic plan for the Commonwealth that aligns prevention, interdiction, enforcement, treatment and recovery support efforts across agencies, and
- Increase our collective ability to reduce the scope and consequences of this systemic problem across the state.

The report said, "We envision a system in which individuals, families, communities and service agencies work cooperatively to prevent and treat substance abuse and addiction. Through the work of the Interagency Council on Substance Abuse and Prevention, the Commonwealth will make strategic investments for individuals, families and communities most affected by substance abuse."

Principles for success:

- Addiction is recognized and dealt with as a chronic disease.
- Potential users receive prevention services before they ever use.
- Effective interdiction and enforcement efforts reduce the availability and the pervasive impact of drugs.

- People needing treatment and/or other interventions are identified early, effectively and efficiently.

- Individuals receive effective assessments and are consistently placed in the most appropriate levels of care.

- A continuum of services, with supply corresponding to appropriate demand, is available and is well managed.

- Prevention, treatment and support services are timely, appropriate and effectively delivered.

- Reducing substance abuse and addiction is a government and community-wide fight. Successful strategies involve both levels.

The report stated, "Addiction is a chronic, relapsing disease. Left untreated, its consequences take a significant human toll and have an enormous impact on multiple systems. Its physical consequences range from illness and disability to death. Its social consequences include traffic accidents, crime, job loss, homelessness, domestic violence, and child abuse and neglect, among innumerable others. Alcohol was involved in 45% of fatal automobile crashes in 2003. People with drinking problems use healthcare services at twice the rate of others. Eighty-three percent of those arrested were using alcohol or other drugs at the time of their offense. Most aspects of our society, and every aspect of our social service and criminal justice systems, bear a significant impact from substance use disorders. The impact on all our public systems and professionals is extraordinary – from the court system to corrections, emergency rooms to homeless shelters, and from police officers to school teachers.

Massachusetts' approach to the issue of substance abuse and addiction is not yet sufficiently comprehensive, well organized or systemic when dealing with the many facets of substance use disorders. In the past we have generally funded services, not strategies. Some population groups, left untreated, impose significant costs on the Commonwealth, especially those who rely upon programs and services of multiple state agencies. We must coordinate all of our efforts related to prevention, interdiction, enforcement, screening, assessment, treatment and support. As other states have discovered, better coordinated services will reduce recidivism, increase retention in treatment and provide the long term supports needed by people in recovery."

Statistics from the report/presentation follow:

- Massachusetts has high levels of alcohol and drug use. Massachusetts residents use alcohol and drugs at high levels, generally at higher levels than do residents of the nation as a whole. Both youth and adults are affected. Adults at all income and education levels are affected.

- The earlier kids begin using alcohol the worse the impact. The younger a person is when s/he begins drinking, the more likely it is that s/he will be a problem drinker as an adult. A MA Youth Health Survey 2002 showed 13.7% of 6th graders have drunk alcohol in the past 30 days. More than two-thirds (68.9%) of 12th graders have drunk alcohol in the past 30

days, and that use rises steadily by grade level.

- Youth misperceive the relative risks. A National Household Survey on Drug Use and Health 2002 indicated that twice as many Massachusetts youth perceive risk from cigarettes compared with binge drinking or marijuana use. Massachusetts rates of binge drinking and marijuana use significantly exceed national rates, while smoking is similar.

- Massachusetts has higher rates of adult binge drinking than the nation as a whole. Massachusetts consistently ranks among the top ten states for adults' alcohol and drug use. From 1999 to 2002, Massachusetts consistently ranked above the national average for binge drinking (source: Behavioral Risk Factor Surveillance System Survey).

- There are high rates of alcohol and drug use across income and educational levels. About 10% of those with incomes between $35,000 and $50,000 per year use illicit drugs. Rates are roughly half (4%-6%) at other income levels. The rate of illicit drug use is at about the same, relatively high level (7-8%) for adults with less than 4 years of college education (source: Behavioral Risk Factor Surveillance Survey).

- Opioid related hospitalizations & fatal overdoses are increasing for both males and females.

- Arrests and commitments related to substance abuse have held steady or increased since FY1998.

- The mean charge per emergency department discharge FY 2002 was $667.00. The total charges for substance abuse related ER admissions that year approximated $12 million dollars.

- The cost of inpatient detoxification to the Uncompensated Care Pool increased from $2.7 million in the second quarter to $6.3 million in the third quarter of FY 2003, and was at $7.3 million in the most recent quarter.

- Of 30,922 adult women admitted to SA treatment (2003): 504 were pregnant when admitted; 5,077 were homeless; 466 were Section 35 commitments ,75.3% were White, 12.0% were Black, 9.3% were Latino.

- Of adolescent admissions: 72.3% (2,197) were male; 66.1% were white; (12% were black, 16.9% were Latino, 5% were other); 39.7% reported prior mental health treatment.

- Of the homeless population, 78.2% (18,249) were male and 21.8% (5,077) were female, 64.2% (14,980) were white, 96.0% were currently unemployed, 24.0% reported prior mental health treatment

Report Conclusions:

- This strategic plan lays out a direction and set of critical steps needed to stabilize and maximize the impact of the system. It is a beginning. The data we have collected and the

messages we have heard from stakeholders are clear.

- We need more data to monitor our success and make the case for future changes.

- Our prevention and treatment services need to function as a system – now they tend to be isolated and lack coordination between levels of care.

- We need to intervene early to prevent irresponsible drinking and drug use.

- We need to prevent alcohol and drug dependence before they start. This requires broad based screening, standardized assessments, but also new cultural norms for drinking behavior and more proactive interventions by peers.

- We need to develop a system of recovery supports to individuals and families throughout our communities.

- Finally, we need better coordination among public agencies and among purchasers, providers and consumers. Coordination is essential to the redesign of our system.

No Vote/Information Only

PROPOSED REGULATION: INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO 105 CMR 300.000: REPORTABLE DISEASES, SURVEILLANCE AND ISOLATION QUARANTINE REGULATIONS:

Ms. Gillian Haney, Director of Surveillance, Bureau of Communicable Disease Control, accompanied by Ms. Holly Hackman, Epidemiologist, Injury Surveillance Program, presented the informational briefing on proposed amendments to 105 CMR 300.000 to the Council. Ms. Haney said in part, "We are here to advise the Public Health Council of our intent to hold a public hearing on proposed amendments to 105 CMR 300.000: Reportable Diseases, Surveillance, and Isolation and Quarantine Regulations. The proposed amendments would authorize the Department to conduct surveillance (without requiring reporting) for certain injuries of public health importance. In addition, the proposed amendments would update the regulations to add agents with bioterrorism potential to the list of reportable diseases that cause glanders and melioidosis and incorporate the latest federal recommendations for isolation and quarantine."

Ms. Haney continued, "The Department is proposing to add a new section to the regulations on Surveillance of Injuries Dangerous to Public Health (105 CMR 300.193). This section will authorize the Department to collect confidential health information relating to injuries or causes of injuries listed in this section from health care providers and others subject to the regulations. It allows the Department to collect such information for injury surveillance purposes, but does not otherwise require reporting to the Department of confidential injury information. This will allow health care providers and medical facilities covered under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to share confidential injury information with the Department. This information will allow the Department's Injury Surveillance Program and other

Department programs that conduct injury surveillance to investigate causes of injuries and promote injury prevention activities."

Primary Revisions to the Regulations are summarized as follows:

1. 105 CMR 300.020: Definitions. The following items were defined:
   a) Disease
   b) Illness
   c) Respiratory Hygiene/Cough Etiquette
   d) Spinal Cord Injury
   e) Traumatic Amputation
   f) Traumatic Brain Injury

2. 105 CMR 300.100: Diseases Reportable to Local Boards of Health. Glanders and melioidosis have been added to the list of diseases reportable by health care providers.

3. 105 CMR 300.170: Laboratory Findings Indicative of Infectious Disease Reportable Directly to the Department by Laboratories. This list was updated to correspond with all diseases listed in 105 CMR 300.100.

4. 105 CMR 300.191: Access to Medical Records. This new section grants school nurses the authority to obtain from health care providers immunization records or immunization related information required for school admissions, without the specific authorization of the child's parents(s) or legal guardian(s), as necessary to carry out the immunization requirements of M.G.L.c.76§15.

5. 105 CMR 300.193: Surveillance of Injuries Dangerous to Public Health. This section is added to authorize the Department to collect and/or prepare data on individuals evaluated or diagnosed with the injuries specifically listed in this section.

6. 105 CMR 300.200: Isolation and Quarantine Requirements. Proposed revisions are as follows:

Disease	**Isolation of Patient**	**Quarantine of Contacts**
Cyclosporiasis	Food handling facility employees may return to food handling duties after diarrhea has resolved. In certain situations however, food handling facility employees may be required to produce one or two negative stool specimens before returning to food handling duties. If a case has been treated with an antimicrobial, the stool specimen shall not be submitted until at least 48 hours after cessation of therapy.	Contacts with diarrhea who are food handling facility employees shall be considered the same as a case and handled in the same fashion. In certain outbreak situations, asymptomatic contacts who are food handling facility employees may be required to produce one or two negative stool specimens. Otherwise, no restrictions.

Diphtheria	New Requirements: Maintain isolation until two successive pairs of nose and throat cultures (and cultures of skin lesions in cutaneous diphtheria) obtained ≥ 24 hours apart and at least 24 hours after completion of antimicrobial therapy are negative. If there was no antimicrobial therapy, these two sequential pairs of cultures shall be taken after symptoms resolve and ≥ two weeks after their onset. If an avirulent (nontoxigenic) strain is documented, isolation is not necessary.	All contacts (both symptomatic and asymptomatic) whose occupations involve handling food must be excluded from that work until two successive pairs of nose and throat cultures obtained ≥ two weeks after completion of antimicrobial prophylaxsis (if any) ≥ 24 hours apart are negative. Symptomatic contacts who are not food handlers shall be considered the same as a case until their culture results are negative and they are cleared by the Department. Asymptomatic contacts who are not food handlers must be on appropriate antibiotics and personal surveillances. These requirements may be extended to other contacts who work in high-risk transmission settings, as determined by the Department.
Glanders (newly added to regulations)	No restrictions	No restrictions
Hepatitis A	No change	No restrictions except for susceptible food handling facility employees, who shall be excluded from their occupations for 28 days unless they receive a prophylactic dose of Immune Globulin (IG) within 14 days of exposure.
Melioidosis (newly added to regulations)	No restrictions	No restrictions
Typhus	No restrictions	No restrictions
Varicella (Chickenpox)	If vesicles are present, until lesions have dried and crusted, or until no lesions appear, usually by the fifth day (counting the day of rash onset as day zero). If no vesicles are present, until the lesions have faded (i.e. the skin lesions are in the process of resolving; lesions do not need to be completely resolved) or no new lesions appear within a 24-hour period, whichever is	Susceptible students or staff in non-health care settings, who are not appropriately immunized or are without laboratory evidence of immunity or a reliable history of chickenpox, shall be excluded from school from the tenth through the 21st days after their exposure to the case while infectious with rash (not including the prodrome). If the exposure was continuous,

	later.	susceptibles shall be excluded from the tenth through the 21st days after the case's rash onset. In high-risk settings, the Department may impose more rigorous exclusion criteria. Neonates born to mothers with active varicella shall be isolated from susceptibles until 21 days of age. Health care workers who are not appropriately immunized or are without laboratory evidence of immunity or a reliable history of chickenpox shall be excluded from work (or isolated) from the tenth day after their first exposure during the case's infectious period (including the prodrome) through the 21st day after the last exposure during the case's infectious period. Anyone receiving varicella zoster immune globulin (VZIG) shall extend their exclusion to 28 days post-exposure.

7. 105 CMR 300.300: Required AIDS Education. This language was revised to reflect that a premarital blood test for syphilis is no longer a requirement in Massachusetts.

Ms. Holly Hackman, Epidemiologist, Injury Surveillance Program, addressed the Council. She said, "This proposed regulation will allow health care providers and medical facilities covered under the Health Insurance Portability and Accountability Act, HIPAA Privacy Rule, to share confidential injury information with the Department. This information will allow the Department's Injury Surveillance Program and other Department programs to conduct injury surveillance to investigate the causes of these injuries and promote injury prevention activities. These injuries are assault, homicide, suicides, attempted suicides, self-inflicted wounds, drowning, falls, fires, weapons, machinery, any mode of transportation, strikes by or against another object or person, suffocation, poisoning, including but not limited to drug overdose, traumatic brain injuries, spinal cord injuries and traumatic amputation."

Staff noted in conclusion, "Adoption of the proposed regulations will allow the Injury Surveillance Program to undertake surveillance of injuries of public health importance. It will also allow the Department to establish reporting requirements for the potential bioterrorism agents that cause glanders and melioidosis and incorporate the most recent federal recommendations for isolation and quarantine."

NO VOTE/INFORMATION ONLY

PROPOSED REGULATION: REQUEST FOR FINAL APPROVAL OF 105 CMR 661.000: REGULATIONS THAT IMPLEMENT CH. 270, §22:

Ms. Sally Fogerty, Associate Commissioner, Center for Community Health, accompanied by Atty. Howard Saxner, presented the request for final approval of regulations 105 CMR 661.000. Ms. Fogerty noted in her memorandum to the Council and/or stated, "…The Massachusetts Smoke-free Workplace Law (c.270,§22) went into effect on July 5, 2004…After an initial period of implementation, regulations addressing the most notable remaining enforcement issues were drafted by Department staff and presented to the Public Health Council on April 19, 2005. A public hearing was held on June 3, 2005. We are here today to request approval to promulgate the regulations."

Ms. Fogerty continued, "There has been a high level of compliance with the law throughout the Commonwealth. Local boards of health are reporting rates of 90% compliance to the Tobacco Control Program. However, Department staff has identified two areas that seem to need clarification through regulation:

1. The Tobacco Control Program has received calls from both hospitality businesses and local boards of health requesting clarification on issues related to smoking in outdoor dining areas such as patios, decks, tents and partially enclosed rooms. While the law prohibits smoking in enclosed areas of workplaces, it permits smoking in outdoor spaces of such establishments. A number of questions have arisen as to where to draw the line between enclosed and outdoor spaces. The purpose of the regulations is to provide guidance around the amount of open space that is necessary for a space to be considered an "outdoor space" for purposes of the statute.

2. Another area where the Tobacco Control Program has received feedback from the business community regards membership associations, which are also known as private clubs. The law exempts these organizations from smoking restrictions when they are not open to the public. It appears that some membership associations operate strictly as private clubs and therefore are exempt from the law. Other membership associations, however, appear to the public or permit regular access by persons who are not members of the association.

Ms. Fogerty said further, "The Tobacco Control Program and local boards of health have received many calls from restaurant and bar owners who perceive these membership associations to be operating as public bars rather than private clubs. While the issue of what constitutes membership is a difficult one, the regulations seek to define membership in a way that is consistent with the intent of the Smoke-free Workplace Law and policies of the Alcoholic Beverage Control Commission. If a membership association is only serving its members and is not open to the public, these regulations would have no impact on it. Department staff also received feedback on these issues from a special commission mandated by the statute to oversee implementation of the law. The commission met three times in the year following passage of the legislation. In addition to providing information and other recommendations for Department action, it agreed that the two concerns outlined above

should be addressed in regulations and gave approval to the draft of the regulations that went to public hearing."

It was noted that the public hearing was held on June 3, 2005 and written comments were accepted until June 10, 2005. Thirteen individuals or organizations submitted testimony to DPH, including eight individuals who testified at the public hearing. Seven of the 13 supported the DPH regulations, including the Massachusetts Association of Health Boards, Massachusetts Health Officers Association and Tobacco Free Mass Coalition. The remaining six individuals had no comment on the DPH proposed regulations. These individuals testified in opposition to the law and the negative impact of the law on their businesses.

Proposed Regulations:

Membership Associations:

With respect to smoking in membership associations, the regulations would prohibit smoking in an enclosed indoor space of a membership association that is open to the public. This prohibition would extend to a membership organization that invites or encourages non-members to enter the premises. Smoking also would be prohibited if the space is occupied by a non-member who is not a guest, rented from the association for a fee, or occupied by an independent contractor, contract employee or temporary employee. Smoking would be permitted in a membership association if the premises are occupied solely by members of the association who have joined the association under the terms of membership that are comparable in duration and cost to the terms of a full membership. Smoking also would be permitted if the premises are occupied by invited guests or salaried employees of the association, or visiting members of an affiliated chapter of a fraternal lodge organization. The regulations also permit smoking in a distinct part of the premises of a membership association, provided the space is separated physically from an area open to the public and occupied solely by those persons noted in the paragraph above.

Outdoor Spaces:

Smoking may be permitted in an outdoor space that is physically separated from an enclosed work space if there is no migration of smoke into the enclosed work space. The regulations define an outdoor space as being open to the air at all times, which means a thorough, unobstructed circulation of outside air to all parts of the outdoor space. Department staff received feedback from local boards of health, which bear primary responsibility for enforcing the regulations, that they would like a relatively bright line test for what constitutes an acceptable outdoor space. Accordingly, the regulations establish two relatively concrete tests (based upon whether or not the space has a ceiling) for when outdoor spaces are to be regarded as open to the air. Ms. Fogerty said, "It is worth noting that the only change in the regulations between the version that went to public hearing and the version now before the Public Health Council can be found in section 661.200 (A), where the words 'when the walls or covers are in place' have been added. This makes clear that a space with a structure capable of being enclosed will be regarded as an enclosed space only when the walls or

covers are in place."

Miscellaneous:

The regulations also address two areas where the Department is required by the statute to adopt regulations. First of all, the regulations set minimum standards for professional testing laboratories engaged in research on tobacco products. Secondly, the regulations define what constitutes 'egregious non-compliance' with the statute. Chapter 270, §22 authorizes local boards of health to revoke or suspend a license or permit where there is 'egregious non-compliance.' Finally, the regulations authorize the Department and the Alcoholic Beverages Control Commission to enforce the statute through use of a 'non-criminal disposition' ticketing process."

Ms. Fogerty noted, "In a report released in April by the Harvard School of Public Health, evaluating the impact of the law, the sales tax revenue for food and alcohol has remained stable since the implementation of the law, as has the number of hospitality industry employees. Twenty-seven establishments measured before and after July 5th actually showed a significant improvement in the air quality."

After consideration, upon motion made and duly seconded, it was voted unanimously [Mr. Sherman did not vote] to approve the **Request for Final Approval of 105 CMR 661.000: Regulations that Implement c.270, §22;** that a copy be forwarded to the Secretary of the Commonwealth; and that a copy be attached and made a part of this record as **Exhibit No. 14, 816.**

REQUEST FOR APPROVAL TO PROMULGATE EMERGENCY AMENDMENTS TO 105 CMR 130.000 HOSPITAL LICENSURE REGULATIONS DEFINING "RURAL HOSPITALS":

Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control, accompanied by Ms. Sally Fogerty, Associate Commissioner, Center for Community Health Services, presented the request for emergency promulgation of amendments to 105 CMR 130.000 Hospital Licensure Regulations. He noted, "We are here to seek the Council's approval to promulgate an emergency amendment to 105 CMR 130.000, hospital licensure regulations. The Department is seeking emergency promulgation to ensure that Massachusetts retains the authority to have its own, state-specific, definition of "rural hospital" as the term applies to eligibility for the certification of small hospitals in rural communities as Medicare Critical Access Hospitals (CAHs)."

Dr. Dreyer continued, "This amendment is needed to ensure that three hospitals in rural communities (Fairview Hospital, Great Barrington, Martha's Vineyard Hospital, and Nantucket Cottage Hospital) are able to maintain their current federal status as a Medicare CAH for purposes of receiving cost-based federal Medicare reimbursement. It will also allow two other eligible small hospitals, which are considering CAH conversion, to seek this designation in early fall 2005 and become converted by the impending federal deadline. The ability to qualify for a CAH designation is essential because CAHs receive enhanced, cost-based, federal Medicare

reimbursement to assist with maintaining the viability of local health care services in the more remote and less densely populated rural communities. Since the inception of the Medicare Rural Hospital Flexibility Program in 2000, all states, including Massachusetts, have been able to adopt a definition of 'rural' in their State Plan that is most appropriate for their jurisdictions. However, provisions of the federal Medicare Modernization Act of 2003 being implemented are sun-setting states' authority to maintain a state-specific definition of 'rural' for us in certifying Medicare CAHs unless there is a state definition codified in state law and regulation….This regulation change will ensure that the small rural Massachusetts hospitals currently certified as Medicare CAHs continue to be designated as such, and will also allow for two additional hospitals in rural communities to become certified within the next four months."

After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve the Request to **Promulgate Emergency Amendments to 105 CMR 130.000: Hospital Licensure Regulations defining "Rural Hospitals"**; that a copy be forwarded to the Secretary of the Commonwealth; and that a copy be attached and made a part of this record as **Exhibit No. 14, 817.** This emergency amendment specifies the definition to be used for eligibility as a Medicare Critical Access Hospital: "Rural Hospital," means an acute care hospital licensed under M.G.L.c.111, §51, which (1) has 50 or fewer licensed beds and based on the published United States Census 2000 data of the US Census Bureau is in a city or town whose population is less than 20,000 and is located within a city, town, service area, or County whose population density is less than or equal to 500 people per square mile and which applies for such a designation; or (2) is a hospital designated a Critical Access Hospital as of July 1, 2005 by the Federal Department of Health and Human Services in accordance with federal regulations and state requirements. This amendment becomes effective upon filing with the Secretary of State's Office; the Department will hold a public hearing in August to receive comments and then will return to the Council for final promulgation.

REQUEST FOR PROMULGATION OF EMERGENCY AMENDMENT TO DETERMINATION OF NEED REGULATIONS 105 CMR 100.000 GOVERNING APPLICATION FILING DAYS FOR INNOVATIVE SERVICES AND NEW TECHNOLOGY:

Ms. Joan Gorga, Acting Director, Determination of Need Program, presented the emergency amendment request to the Council for regulations 105 CMR 100.000. Ms. Gorga said in part, "…This amendment changes the filing day of applications for Neonatal Intensive Care Unit (NICU) from the first business day of August 2005 to the first business day of August 2007. The current emergency promulgation is necessary because the Department and its Perinatal Advisory Group are currently in the process of holding public hearings on the maternal and newborn care sections of 105 CMR 130.000 (the hospital licensure regulations) on which the Public Health Council was briefed at the June 28, 2005 meeting. The final promulgated regulations, which may affect the DoN process in addressing the need for NICU beds, will not be completed in time for the August 2005 filing day of NICU applications."

After consideration, upon motion made and duly seconded, it was voted unanimously to approve the Request for Promulgation of **Emergency Amendment to Determination of Need Regulations 105 CMR 100.000 Governing Application Filing Days for Innovative Services**

and New Technology; and that a copy be forwarded to the Secretary of the Commonwealth; and that a copy be attached and made a part of this record as **Exhibit No. 14, 818.** This amendment will be effective upon filing with the Secretary of State's office and will remain in effect for 90 days. A public hearing will be held on the proposed emergency amendment in August. Department staff anticipates returning to the September 27, 2005 meeting of the Council with the final version of the regulation for adoption.

CATEGORY 2 APPLICATION:

DoN PROJECT APPLICATION No. 3-3A95 of BRN CORPORATION, HAVERHILL, MA: - SUBSTANTIAL RENOVATION TO REPLACE AND RELOCATE 60 EXISTING LICENSED ACUTE REHABILITATION BEDS FROM WHITTIER REHABILITATION HOSPITAL IN HAVERHILL TO A NEW SITE IN BRADFORD, MA:

Ms. Joan Gorga, Acting Director, Determination of Need Program, made introductory remarks, accompanied by Attorney Carol Balulescu, Deputy General Counsel. Mr. Jere Page, Senior Analyst, Determination of Need Program, presented the BRN Corporation application to the Council. Mr. Page stated and/or noted in the staff summary, "…The applicant, BRN Corporation ("Applicant" or "BRN") is a new corporation, established to develop and operate the new rehabilitation hospital in Bradford, which will house the 60 relocated acute rehabilitation beds. BRN is part of the Whittier Health Network ("Whittier"), which is a provider of comprehensive acute rehabilitation and long term care services in Massachusetts, and which operates two acute rehabilitation hospitals, seven long term care facilities, a home health care agency, and a pharmacy. The applicant has filed a Determination of Need ("DoN") application for substantial renovation of an existing two-story, 102,640 gross square foot facility at 145 Ward Hill Avenue in Bradford to replace and relocate all 60 existing licensed acute rehabilitation beds currently in operation at the Whittier Rehabilitation Hospital at 76 Summer Street in Haverhill ("Whittier-Haverhill), which was established in 1982. The Bradford site is 4 miles from the Haverhill site. The applicant reports that the new two-story facility in Bradford will be a full service, state-of-the art rehabilitation facility, designed to replicate the 88-bed Whittier Rehabilitation in Westborough ("Whittier-Westborough"), which opened in 1997. The applicant believes that the proposed new Bradford facility will be similar to the Whittier-Westborough facility in that the applicant will take advantage of a favorable commercial real estate market and acquire an existing building in Bradford in proximity to the existing Whittier-Haverhill facility, which will offer ample space in a configuration that is adaptable to the functional needs of acute rehabilitation services, and will also allow significant savings to be realized in the purchase price, as well as the renovation cost of the facility. The applicant expects all the renovations at the new Bradford facility to be completed by March 2007."

Mr. Page noted the applicant's reasons for requesting the new site, "…The Whittier-Haverhill facility was constructed in 1958 as a chronic care facility and is located in a residential neighborhood in the city's downtown area. Whittier-Haverhill was originally licensed to operate a 122-bed acute rehabilitation hospital, but from the beginning has been seriously constrained in its ability to offer acute rehabilitation services by the size and configuration of the building, to the extent that only 60 acute rehabilitation beds are currently licensed and in operation in Haverhill. Whittier-Haverhill is also constrained by a number of site limitations, particularly with available

land for expansion. As a further indication of need for the proposed relocation of the 60 beds to the new Bradford facility, the applicant reports that Whittier-Haverhill has received numerous waivers from the Department of Public Health relating to a lack of space needed to meet the current Department licensure standards, and that this insufficiency of space manifests itself in a number of key areas that affect the facility's operating efficiency and scope of rehabilitation services, including the following: patient rooms (not enough private rooms, only has two which limits its ability to serve patients on infection precautions or with special needs; and rooms very small, lacking space for storage of wheelchairs and other equipment needed by rehab patients); Nurse stations too small so clinical staff must use one of two examination rooms to perform documentation responsibilities; Aqua Therapy can't be provided because they have no space for pool or aquatic therapy equipment; outpatient therapy – currently limited to six treatment rooms so cannot offer full range of outpatient programs such as pulmonary, cardiac, and stroke rehabilitation; patients must wait a long time or find treatment at other rehabilitation facilities; lack of space requires that the Community-Re-Entry Program must take place off the premises for the most part; Medical Records Department must use secure off-site record storage, which results in extra cost and inefficiencies; Office Space: over-crowding shared office space; and Storage Space: a needed outpatient staff lounge has been given up to serve as a wheelchair storage room.

Mr. Page further noted that the applicant acquired an office building that they will renovate at a cost savings since a new hospital would probably approach 50 million dollars; whereas, the maximum capital expenditure for this project is 21 million dollars.

In conclusion Mr. Page said, "Based on our analysis, staff finds that the substantial renovation to replace and relocate 60 existing licensed acute rehabilitation beds is necessary for the applicant to be able to meet current Department licensure standards, increase inpatient capacity through greater efficiency without adding new beds, improve patient access, and add a broader range of therapies to provide state-of-the-art acute rehabilitation services."

As noted on page three of the minutes, Brad McDougall addressed the Council on behalf of Congressman Marty Meehan of the fifth District. He said in part, "I am pleased to extend Congressman Marty Meehan's support for the Whittier Rehabilitation Hospital's Determination of Need application. I am honored that you folks have taken the time today to listen to Congressman Meehan's opinions on this matter. 'Commissioner Cote and Director Gorga, I am writing to support the Whittier Rehabilitation Hospital's Determination of Need application for substantial renovation and replacement of the sixty existing licensed acute rehabilitation beds from downtown Haverhill to a new location in the Bradford section of the city. I am pleased to offer my support for this project and thank you for your continued support of the Whittier Rehabilitation Hospital's outstanding work in its communities throughout the Commonwealth and specifically in Haverhill. The Whittier Rehabilitation Hospital offers comprehensive and individualized medical care which can be expanded through this very project. Patients, families and communities throughout this Commonwealth will directly benefit from their investment in continued excellence. These benefits have a large impact on the community and health care….Among them are the outpatient service and expanded service to deal with the rising demand within the community, and the need for continued health care coverage for these individuals and patients that need rehabilitation services. The Whittier Health network is a family-owned business, provides high quality care, and has been nationally recognized for over twenty-three years. The renovation and replacement of this facility

will enable significant enhancement to their delivery of health care. I can confidently recommend that the Determination of Need application for this new facility be granted. Therefore, I respectfully request that you move forward with the Determination of Need application for the Whittier Rehabilitation Hospital, and if you have any questions, please contact Mr. Congressman Marty Meehan, or myself, and we are honored to support Whittier Rehabilitation Hospital and networks on their behalf on this application.'"

State Senator Steve Baddour, of the First Essex District, testified before the Council. He said, '…It is great to be here on behalf of Whittier health care network. I can tell you, as someone who has been in the legislature for three years that, prior to serving in that role, I was Assistant Attorney General and I was in private practice prior to that in the health care field, and Whittier has a terrific reputation though the Merrimack Valley. They have been providing high quality care throughout Massachusetts, specifically in the Greater Haverhill area, for well over 23 years. It is a very well respected institution. It is run by a family-owned business. I can tell you that they are, without a doubt, really community driven, and this is a great opportunity to really expand Whittier, to expand the services that they provide to the greater Merrimack Valley residents. I can tell you from a personal perspective, I have actually been there for rehab services. I have four bulging disks in my back. I can tell you, the quality of care there is terrific. I have had family members there who have broken hips, all different types of needed services, and every single time the quality of care provided has been terrific, and I can assure you that this is a terrific and a great opportunity for not only Haverhill, but for the residents of the Merrimack Valley, to allow for this expansion.. Rep. Dempsey and Representative Stanley support this application also."

The applicant, Alfred J. Arcidi, Senior Vice President addressed the Council. He noted, "…I would like to take this opportunity to explain some of the reasons why we applied for substantial renovation to relocate the sixty existing acute rehabilitation beds from Whittier Rehabilitation in Haverhill to the new location four miles away in Bradford. Our goal is to provide the Merrimack Valley and the Commonwealth of Massachusetts a truly comprehensive, state-of-the-art rehabilitation facility, one that will offer a full range of services and meet the specialized needs of patients with complicated diagnoses, like severe stroke, traumatic brain injury, and spinal cord injury. We also continue to provide the best in care to those routine rehabilitation needs such as those recovering from a bone and joint surgery, deconditioning due to prolonged illness, and those suffering from cardiac and pulmonary disease."

Mr. Arcidi continued, "Whittier is currently trying to provide hospital level care in an antiquated facility. Whittier currently has eleven waivers with Massachusetts Department of Public Health related to our space to meet current state standards. These waivers greatly affect the hospital's operating efficiency and services that it can provide. Whittier would also like more space so they can offer community health related programs and workshops as its sister facility has done in its Westboro facility. In Westboro, Whittier regularly offers health education programs on important health issues such as smoking cessation, stress management, nutritional counseling, as well as many other topics. Whittier has also invited the community to use its space for its own programs, such as AA…Whittier believes that approval of the project will offer a cost effective replacement of an outdated and overcrowded hospital facility with a new state-of-the-art facility, increased patient capacity for greater efficiency; i.e., by having more private rooms, we can accommodate more patients without adding new beds to our license; a broader range of rehabilitation services,

particularly in the area of aqua therapy and community reentry; more space to serve the growing community's demand for outpatient services, and new therapy equipment; improved access to a more convenient location for patients and their families."

"This would come at no additional cost to the state, Mr. Arcidi said, "due to the reimbursement from Massachusetts Health Recipients as a prospective payment methodology. We also hope to create the increased volume of additional jobs to health professionals throughout our community. Whittier has already had a positive experience with renovating a large commercial building in an industrial area, such as Bradford, to a hospital. In Westboro, Mass., we renovated a former Digital building into a state-of-the-art rehabilitation facility. It was the first time ever in the state of Massachusetts that a building not originally built as a hospital was renovated and used successfully as a hospital."

In closing, Mr. Arcidi noted, "Whittier gladly accepts the Staff's recommendation to approve this application with conditions. In short, Whittier hopes to provide the Merrimack Valley and the Commonwealth of Mass. with a state-of-the-art rehabilitation facility that can provide the very best in rehabilitation services, as well as a community resource for health information and education."

Mr. Philip Arcidi, Treasurer of BRN Corporation, answered a question from the Council, explaining that they owned nursing homes across Massachusetts that provide in and out patient rehabilitation services (seven or eight facilities). He noted that they feel that their competition, Northeast Rehabilitation Hospital, located in Salem, New Hampshire is behind the Mark Taylor Ten Taxpayer Group (TTG) and that approval of their new facility will probably hurt that facility because right now patients utilize the services there because Whittier cannot offer the services needed presently without this approval.

Attorney Carl Rosenfield, representing the Mark Taylor Ten Taxpayer Group (TTG) addressed the Council. He said, "…Let me just start by addressing the last point that Mr. Arcidi made about the identity of the Ten Taxpayer Group. The statute and the regulations don't limit the ability of any interested parties to file and participate in the process. Sometimes they are competitors. Sometimes they are community groups. Sometimes they are neither. I think you have to look at the whole purpose of the process and the involvement of the TTG, which I think, at least in some large part, is to enable a full exposition of the issues attendant to any application that is filed, and to offer an alternative look than may have been presented by the applicant and the staff, and that is what we are doing here today."

Atty. Rosenfield continued, "…When you look at this application, it is really predicated on the DoN guidelines for acute rehabilitation services that enable existing licensees, under certain circumstances, to engage in a one-for-one replacement of existing beds. Just accepting that proposition, that doesn't mean that you can phone in the result, that the DoN program is a program governed by the rules which are established in regulation, statute, and guidelines, and in this case, we assert that the rules haven't been followed in a number of material respects. We also assert that there hasn't been the kind of critical review and analysis by the Department staff that is warranted by an application of this magnitude….We submitted a lot of material. You have it in your packets. What I will try to do is hit the most significant points. But the failure to follow the rules really go to the eligibility of the applicant to file as an existing licensee, and its compliance with the factors

for review. Moreover, throughout the application, there is a certain inconsistency in which, the way the applicant has been treated by the staff. We also contend that there are some important policy considerations that we request that you consider in reviewing the application and deciding whether to adopt the conditions that we have recommended. Let's first look at the financial capacity of the applicant because that is one of the items that any applicant for DoN approval has to establish. What the application itself doesn't contain is any reference to the fact that there is an existing 13.5 million dollars in debt associated with Whittier Rehabilitation Hospital. The application is proposing an additional 19.4 million dollars in cost in finance, which would leave a total of 32.9 million dollars in debt, which is associated with Whittier Rehabilitation Hospital, on both buildings."

Atty. Rosenfield said further, "Now, the way staff treats this is, it says that HUD which is the guarantor of the potential loan, is going to treat the application, in this case the BRN, which is not the existing licensee. The licensee is HBL Corporation, but the Staff asserts, because there is common ownership, BRN can stand in the shoes of HBL and this application for the replacement of Whittier. The Staff refers to HUD treating BRN as a new entity by not requiring that the two loans be consolidated. But if you look at the staff analysis, and what it is talking about in terms of its communication with HUD, HUD seems to be, by the staff's own admission, somewhat concerned with the existing debt because what the staff has related is that HUD will either require the retirement of the debt if the existing building is used for non-health related purposes, or if it is going to be used for health related purposes, HUD would require a demonstration of how the applicant is going to be able to service both of those loans. So it is fair to say that by staff's own admission, HUD has some concern about the existing debt, which stands to reason…Staff hasn't done their own independent, critical analysis of the financial capability of the applicant to handle this kind of debt. DPH has an obligation to assess independent from the lender, or the guarantor, the financial capacity of the applicant, and at least require some demonstration that either the existing debt is going to be retired or that they can service this debt."

Atty. Rosenfield also noted the following:

- Fixed cost coverage ratios, when one factors in the existing debt, the ratio drops significantly below the DoN required minimum of 1.4.

- Most recent audited financial statement of year ended September 2004 has not been submitted; DoN has audited financial statement of year ended in September 2003.

- The application was accepted by DoN on June 22, 2005. DoN did not receive documentation of standing from the Applicant until June 29, 2005, 7 days later.

- Guidelines state that current licensees have one point replacement. TTG doesn't understand why BRN can stand-in for HBL. He stated that staff allows this because the Arcidi family owns both entities. TTG doesn't think the Department should allow this.

- TTG states that staff misconstrued their comments on the licensee issue. TTG is saying that staff should scrutinize the creation of a new licensee becoming a licensee of a health

facility.

- TTG suggested certain conditions of approval: (1) Requirements that the existing building cannot be used for inpatient use since the applicant indicated that the building was physically deficient for that purpose; and (2) requested a condition that would discourage the applicant from constructing excess space to avoid cost limitations on future expansions.

In closing, Atty. Rosenfield stated, "I think we have been able to demonstrate that the staff has failed to follow its own rules, and the applicant has failed to follow the rules in a number of instances. I think it is important to note that staff has treated the applicant inconsistently by treating it as a new entity in reviewing the financial feasibility and capacity of the applicant, but to allow it to stand in the shoes of the existing licensee for the purpose of establishing eligibility. So, it is either a new entity or it is not a new entity. If it is a new entity then it should be prohibited from filing this application, or at least prior to their being a transfer of ownership. If it is not a new entity, then you have to look at the totality of the financial situation."

Council Member Ms. Pompeo added, "I spent all of my formative years in state government, in the state Medicaid program, most recently working with types of decisions regarding financial feasibility and knowing the DoN staff for 25 years, I trust them and I know that guidelines allow for interpretive qualities, and that those qualities are sometimes based on fact, and sometimes based on tremendous experience. The provider has been around for a long time. I remember when they first came to Massachusetts and took over some bankrupt facilities. I think that, knowing the intention here is to promote the quality of the care that is delivered in that region by providing a better building and knowing the standing reputation of the applicant, it's hard for me not to go with what the staff knows with their professional experience. And on the issue of HUD, I understand again, from a regulatory perspective, why it is concerning, but the reality is, it is HUD's issue to resolve and I would have to say, you have raised some very good, logical arguments….Certainly you have experience in these types of matters, but I can't imagine that the overriding intention of improving the location of the care delivered shouldn't take precedence here, particularly given what we know about this applicant."

Council Member Mr. George asked, "Are the patients going to be better off in this facility than the facility that they have today, forgetting all the concerns and I respect your stating of the regulations. How are the patients? Are the patients going to be better off?"

Atty. Rosenfield replied, "Yes, but only if the facility maintains a financial viability because nobody is going to be better off if these kinds of expenditures are undertaken, and this kind of debt is incurred, and then the enterprise fails."

State Representative Harriet Stanley of Second Essex District, submitted a letter of support and testified to the Council. She said in part, "….As Mr. George just pointed out, the real point of this facility, and I think the most compelling argument of this facility, is made for what it will do for the patients, not only in the Haverhill Region, but in the Greater Merrimack Valley Region. And as a person who has personally been through rehab, although not at the Arcidi's facility, I can tell you that it offers the kinds of increased access to real life settings that people actually need to go

through, and many of you don't know this, but I went through brain surgery in 2001, and had to go through fairly extensive rehab, which was able to be done largely in a home setting because there were not any other kinds of settings available to me at that time. The point I would like to make is that this family is committed to health care, and not really committed to health care for their own business purposes, and they are very active in the Haverhill community and in fact the entire Merrimack Valley…and I think that, in these times of shrinking to static resources and greater and greater patient need, that that is an important factor – that they reach out to the community, people want to go to their facilities and they are known as a factor in the community. For those, two reasons, because I personally had experience with rehab and second of all because the Arcidi family is very active, I would urge you to approve Staff's recommendation."

In response to the comments by the TTG, Attorney Carol Balulescu, Deputy General Counsel, Department of Public Health, addressed the Council. She said, "You have the comments summarized and staff reaction in your packets, so I will try to be brief with this. There was some dispute over interpretation of the regulations and the Legal Department did, in fact, look at some of the allegations by the Ten Taxpayer Group and determine that the regulations were, in fact, appropriately followed. When we interpret the regulations, we look at the requirement for a fair and open process, and try not to use regulations to throw up obstacles into an otherwise approvable application. There were discussions with the applicant and with the Ten Taxpayer Group on some of these issues and, again, we do believe that this resulted in a fair and open process for all of the parties, and that the concerns were addressed. One example is the standing issue. Certainly the Department would not find standing if there were serious questions about the site and the ability of the applicant to present sufficient evidence of ownership of the site. The Department really had no concerns about that and, in terms of getting backup documentation, it was just a matter of the Department dotting the i's and crossing the t's but, again there was never any concern on the part of the Department that the site was not, in fact, controlled by the applicant. The other issues are addressed in the comments. If you do have specific questions about any of the specific issues raised, I would be happy to address them."

Council Member George asked staff, "Are you satisfied that the applicant has the financial capacity to service the debt?"

Mr. Page, Determination of Need Analyst for the project, responded that he had a very long conversation with one of the Regional Directors of HUD, who informed him that HUD would be glad to entertain the financing of this facility in Bradford and he also said that if the old building was going to be used, HUD would have to see some evidence that that would be worked through in order to get HUD approval. The HUD Regional Director further said that in his experience, the Whittier facilities had been successful, not only the rehab hospitals but the long term care nursing homes, and that they would look forward to going ahead and entertaining further financing of this new project.

Council Member Pompeo asked Attorney Carol Balulescu, Deputy General Counsel, Office of the General Counsel, Department of Public Health, about Ten Taxpayer Group rights and what about the TTG's relationship to a competitor. She said in part, "What is the obligation of the State Agency or the Council to deal with out of state competitors?" Atty. Balulescu responded, she said in part, "…the regulation does give any ten taxpayers, citizens of the Commonwealth, the right to

form a group and lodge their objections or raise any issues. The Department has an obligation to review and respond to all concerns raised, and as long as the Ten Taxpayer Group is a legitimate ten citizens of the Commonwealth. We can't look at the motives of the TTG in responding to concerns….We do have an obligation to consider their comments and respond to them, regardless of how the Massachusetts Ten Taxpayers may be related to any out of state entity…We should always comply with our own regulations regardless of who is the applicant and who the TTG is."

Council Member Thayer inquired about the debt service ratio mentioned by the TTG. Mr. Page replied, "If HUD views the BRN Corp. as a new entity, it will be around 2.3, which is well above the DoN standard."

After consideration, upon motion made and duly seconded, it was voted unanimously to approve **Project Application No. 3-3A95 of BRN Corporation, Haverhill, MA,** based on staff findings, with a maximum capital expenditure of $21,555,000 (February 2005 dollars), and first year estimated operating costs of $15,128,786 (February 2005 dollars). A staff summary is attached and made a part of this record as **Exhibit No.14, 819**. As approved, this application provides for substantial renovation to replace and relocate 60 existing licensed acute rehabilitation beds from Haverhill to Bradford. This Determination is subject to the following conditions:

1. The Applicant shall accept the maximum capital expenditure of $21,555,000 (February 2005 dollars) as the final cost figure except for those increases pursuant to 105 CMR 100.751 and .752.

2. The total gross square feet ("GSF") for this project shall be a total of 102,640 GSF including 3,000 GSF of shell space to replace and relocate 60 existing licensed acute rehabilitation beds.

3. The Applicant shall contribute 10% in equity ($2,155,500 in February 2005 dollars) to the final approved MCE.

4. Upon implementation of the project, any assets such as land, building improvements, or equipment that are either destroyed or no longer used for patient care, shall not be claimed for reimbursement for publicly aided patients.

5. With regards to its interpreter service, the Applicant shall:

    - Clarify the protocol for accessing interpreter services.
    - Update policies and procedures to prohibit the use of children as interpreters.
    - Update personnel policies to include protections for bilingual staff members who may be called away from their regular duties to provide interpretation.
    - Provide training to staff on effective use of interpreters and/or use telephonic services.
    - Collect data on the number of interpreter encounters.
    - Collect data on the number of telephonic interpreter service encounters.
    - Collect data on the number of interpreter encounters provided by bilingual staff.

- Develop a reliable and valid system for the collection of language, race and ethnicity information from patients.

A plan to address these interpreter elements shall be submitted to OMH within 120 days of the DoN approval. In addition, the Applicant shall notify OMH of any substantial changes to its Interpreter Services Program, and progress reports shall be submitted annually to OMH on the anniversary date of the DoN approval. Also, the Applicant shall follow recommended National Standards for Culturally and Linguistically Appropriate Services ("CLAS") in Health Care.

Staff's recommendation was based on the following findings:

1. The Applicant is proposing substantial renovation to replace and relocate 60 existing licensed acute rehabilitation beds from Haverhill to Bradford.

2. The health planning process for the project was satisfactory.

3. The proposed substantial renovation is supported by the Applicant's need to be able to meet current Department licensure standards, increase inpatient capacity through greater efficiency without adding new beds, improve patient access, and add a broader range of therapies to provide state-of-the-art acute rehabilitation services.

4. The project, with adherence to a certain condition, meets the operational objectives factor of the DoN Regulations.

5. The project, with adherence to a certain condition, meets the standards compliance factor of the DoN Regulations.

6. The recommended maximum capital expenditure of $21,555,000 (February 2005 dollars) is reasonable compared to similar, previously approved projects.

7. The recommended operating costs of $15,128,786 (February 2005 dollars) are reasonable compared to similar, previously approve projects.

8. The project is financially feasible and within the financial capability of the applicant.

9. The project meets the relative merit requirements of the DoN Regulations.

10. The Mark R. Taylor Ten Taxpayer Group (TTG) registered in opposition to the proposed project and requested a public hearing, which was held on June 15 in Haverhill.

The meeting adjourned at 11:45 a.m.

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Paul J. Cote, Jr., Chair

LMH/lmh